

I lay no stress on the circumstance that Dr. Lyons, though describing the condition in which he found the heart in his dissections at Lisbon, says nothing of the one under present consideration, inasmuch as, from his silence on the subject, we cannot conclude that it did not exist. At least such is my belief, founded on the fact that we are nowhere told by that pathologist that he examined the substance of the heart in the only way in which the granular deposits can well be discovered—namely, under the microscope. Be this, however, as it may, this particular morbid change was noticed by Dr. Da Costa in the case already mentioned as having occurred in the Episcopal Hospital. I hasten to state that Dr. Da Costa was not at the time aware of Prof. Riddell's observations on the subject. Dr. D. was kind enough, knowing the interest I take in all matters connected with the yellow fever, to show me the specimen in his possession. I have since seen the same change in another specimen exhibited to me by a friend. Dr. Da Costa, I am told, has also again seen it; and now we find it in both of the cases to which your attention has been invited this evening.

In conclusion I have to state that Dr. Riddell says nothing of the nature or composition of the aforesaid granules. To Dr. Da Costa credit is doubtless due for having decided the question. In the Episcopal Hospital case the heart was found soft and flabby; the muscular fibres were exceedingly granular; here and there oil-drops were seen; the striæ of the muscle were observed; and the granules were to a great extent soluble in ether, but not in acetic acid. I was fortunate enough to witness this examination and experiment, and, were it necessary, which we all know is not the case, could vouch for the truthfulness of the above statement. The same result was obtained in both instances before us. The conclusion from this is that the granules are fatty, the consequence of a commencement of fatty degeneration. I have no hesitation in claiming for Dr. Da Costa credit for the discovery of that fact.

*Nov. 28. Medullary Cancer of the Liver.*—Dr. CHARLES C. LEE presented a specimen of this, with the following observations: The subject of this case was a girl, 22 years of age, born in Glasgow, Scotland. Her father died four years ago, in his sixty-seventh year, of *cancer of the breast*, as she was told by the physician who attended him; her mother and the rest of her family were healthy. The patient herself had no recollection of any ill health before her twelfth or fifteenth year, when she contracted a severe cough. This continued three years, when she came to Philadelphia for medical advice, and was admitted to the Pennsylvania Hospital in June, 1859. Here she remained several months, recovering in some degree from her cough, which, however, returned after she left the hospital, and in the beginning of last January she entered the medical wards at Blockley for the same trouble. In a fortnight she was much better, and was discharged to the out-ward, or almshouse proper; but on the 5th of May she was sent back, with a severe attack of jaundice, accompanied by sharp, lancinating pains in the hepatic region. From that time until her death, on the 24th of November, menstruation was completely arrested, and her health generally became deranged. Although subjected to various plans of treatment by Drs. Da Costa, Judson, and Ludlow, who successively had charge of the case, the liver advanced steadily in size, gradually extending above the ensiform cartilage, and downwards to within a quarter of an inch of the umbilicus, behind to the spinal column, and deeply into the left hypochondriac region in front. Over this space the skin was exceedingly tense; the

whole body was deeply jaundiced and emaciated, except the lower extremities, which remained œdematous until the last.

*Autopsy, thirty-six hours after death.*—Body œdematous, but not equably so; right arm and side generally much fuller than the left, particularly the upper extremity. Eyes and skin of entire body deeply injected with bile; no rigor mortis observable. On opening the abdomen, the liver was found immensely enlarged, extending on the left side three inches, and on the right four inches below the ribs; upwards to between the second and third ribs. The diaphragm was adherent at several points. The right lobe was much more enlarged, proportionally, than the left, and was also soft and fluctuating. The entire weight was  $15\frac{1}{2}$  pounds. When the right lobe was incised, about a quart of thick, dark brown liquid was discharged, consisting, apparently, of broken-down liver-structure, for no pus was perceptible; floating in this liquid were seen, here and there, small masses of whitish pulp. A portion of this fluid was submitted to microscopic examination by Dr. Woodward, whose report is as follows: "The whitish pulp is composed of large spindle-shaped cells in great abundance, a few free nuclei, and large oval cells with single and plural nuclei and nucleoli. A mass of this character imbedded in the substance of the liver would be *medullary cancer* of the liver, and such cancer masses often soften centrally so as deceptively to resemble an abscess, if studied only with the naked eye. They may be single, or several may exist in the same liver, with or without cancer elsewhere." The piece of liver tissue sent to Dr. Woodward was fatty, and so altered as to be scarcely recognizable. In the peritoneum was found about a quart and a half of serous effusion, strongly tinged with bile. The heart was normal; lungs sound, but compressed, especially on the right side. The kidneys and spleen were natural.

*Case of Mola Hydatidosa.*—Dr. KELLER reported this case as follows: Mrs. E., 32 years of age, of healthy constitution, the mother of five children, had her menses last on the 6th of January. She felt otherwise quite well until the 18th of November, when, at 5 o'clock P. M., she was taken with regular labour pains. Four hours afterwards the mass I now exhibit was expelled. She lost but little blood, and the os tincæ contracted readily.

The tumour weighed not quite four ounces, was of an ovoid form,  $1\frac{1}{2}$  inch wide, and  $2\frac{1}{2}$  inches long. On one side it showed a smooth surface, with no appearance of direct vascular communication with the uterus. On the other side there was a perforated empty sac, formed by a thin membrane, covering the undulating surface of the rest of the tumour. In opening that part of the mole next to the womb, it presented a perfect framework of white fibres and cyst-like formations. The fibres were in many instances straight, in others of the rosary-like appearance. They consisted, under the microscope, of connective tissue, covered in many spots with the characteristic villi of the chorion. Some of these were filled with regular cells, others contained only small molecules. In other instances the fibres of the connective tissue ended in cell-formations. The smaller nodules in connection with the fibres were solid, and consisted simply of villi. The larger ones, of the size of small beans, were connected to the framework by minute filaments, and showed on the surface capillaries. I did not examine them, thinking to be able to preserve their characteristic appearance until this meeting of the Society. Next day, however, I found them entirely collapsed. Between this formation and the membrane before mentioned there was an elastic mass, reddish on section, and looking like a fresh fibrinous